STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E506	A. BUILDING _____ B. WING _____	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAINBOW BEACH CARE CENTER	7325 SOUTH EXCHANGE CHICAGO, IL 60649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 406	Continued From page 49 Rehabilitation Services Coordinator) stated R18 was not care planned for aggression towards others in the current care plan. On 7/14/11 at 8:50a.m E8 (PRSC) stated R18 is not in any aggressive individualized behavior management group but was placed on open groups. E8 (PRSC) also stated R18 was just being "childish." Observation on 7/12, 7/13 R18 was not observed attending any groups and he stated he could not find his personal folder for attendance . R18's attendance's sign in records from 1/14 to 7/14/2011 included five days of R18 attending an anger management group for a thirty minute session only. The facility failed to modified R18's psychosocial programing when R18's aggressive behavior continued and to address the effectiveness of the current treatment plan.	F 406		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.625n) 300.625o) 300.690a) 300.3240a) 300.3240b) 300.3240d) 300.3240f) Section 300.625 Identified Offenders	F9999		

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F9999	Continued From page 50	F9999		

n) The facility shall evaluate care plans at least quarterly for identified offenders for appropriateness and effectiveness of the portions specific to the identified offense and shall document such review. The facility shall modify the care plan if necessary in response to this evaluation. The facility remains responsible for continuously evaluating the identified offender and for making any changes in the care plan that are necessary to ensure the safety of residents.

o) Incident reports shall be submitted to the Division of Long-Term Care Field Operations in the Department's Office of Health Care Regulation in compliance with Section 300.690 of this Part. The facility shall review its placement determination of identified offenders based on incident reports involving the identified offender. In incident reports involving identified offenders, the facility shall identify whether the incident involves substance abuse, aggressive behavior, or inappropriate sexual behavior, as well as any other behavior or activity that would be reasonably likely to cause harm to the identified offender or others. If the facility cannot protect the other residents from misconduct by the identified offender, then the facility shall transfer or discharge the identified offender in accordance with Section 300.3300 of this Part.

Section 300.690 Incidents and Accidents

a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the

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F9999	Continued From page 51 progress notes or nurse's notes of that resident. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act) f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act) These requirements were not met as evidenced by: Based on record review and interview, the facility failed to recognize sexual abuse and implement the facility's policy and procedure for investigating, reporting and protecting residents against further sexual abuse/harassment. This	F9999		

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failure involved 6 of 24 sampled residents (R10, R14, R19, R20, R22 and R23) and 3 residents on the supplemental sample (R26, R27 and R31), and resulted in 1 resident (R26) experiencing an alleged sexual assault by 2 residents (R22 and R23). R22 and R23 were listed as identified offenders.

Findings include:

1. On 07/11/11 at 6:55am R1 stated to the surveyor, "They told staff about rape of R26." The survey team investigated the incident and found the following:

The facility incident report form dated 07/3/11 at 4:30pm stated, "R26 went to facility security and alleged that R22 and R23 had touched her breasts and asked her to perform oral sex." The security guard immediately escorted R26 to the nurse. Security left R26 in the custody of the nurse and immediately went to secure R22 and R23.

R26 repeated the allegation she had made to security to the nurse. The nurse immediately contacted the facility supervisor and social services, who were in the building. R26 was interviewed and during that interview stated she had been fondled and "penetrated" by R22 and R23. Local police were notified. The local police responded and took over the investigation which included interviews and evidence collection. R22 and R23 were taken into custody by the police and removed from facility that evening. R26 went to the hospital.

The nurses notes state:

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F9999	Continued From page 53 07/3/11 4:55 pm - As I was going to the floor to do my rounds, as I was getting on the elevator E23 (security Guard) got back on with me and told me that R26 accused R22 and R23 of coming into her room asking for sex. I went to the floor and R26 got on. I asked her what happened, she said they both touched her breast and bothered her. The residents were not on the floor, I informed E1 (Administrator). They were to be given a whenever necessary medication, placed on 1:1 and Z4 (Physician)was to be called and R23 sent out. E8 (Psychiatric Rehab Service Coordinator) was talking to R26, she called me to the room where they were telling me that she said "they penetrated her." I asked R26 was that so and she said "yes". I went downstairs, informed E1 at 5:40pm of the change in accusation, stating now she says they had sex with her. The order per E1 was that both male residents were to go out, and R26 was to be sent out for a rape kit. 6:15 pm - R26 was to be sent out to hospital, and they needed a police report. The police were called. 6:35pm - Police are in the facility and are talking with R26 in E8's (PRSC-Psychiatric Rehabilitation Services Coordinator) presence. 8:20pm R26 was taken to the hospital. 07/4/11 6:10 am - Resident returned per ambulance. Nurse gave report that rape kit result is not yet back. The laboratory rape kit result was not available at the time of the survey. R26 on 07/11/11 at 10:20am stated, "R22 and R23 raped me. They (R22 and R23) went to jail. They went to jail on Saturday. They touched my	F9999		

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F9999	Continued From page 54 breast and penetrated me." R16 on 07/11/11 at 10:40am stated, "My roommate (R26) was raped. She was in another room when (R22) raped her. (R22) and another male (R23) are in jail. There was two male residents involved." E25 (Nurse) on 07/13/11 at 2:15pm stated, "I was passing medication around 4:00pm on 07/3/11. At 4:50pm - 5:00pm. Security Guard (E23) brought her up to the floor. He told me (R26) said (R22) and (R23)were touching her breast and told her to "Suck D---." She also stated, "They penetrated me." Immediately asked (R26) what happen. She repeated the same statement. Security guard brought (R22) and (R23) up. I gave whenever necessary medication to (R22) and (R23). The police were called and report done. They were taken to the local jail." The following incidents were also found involving R22 and R23. On 06/14/11 7:00pm - Resident (R22) was involved in incident with another resident. (R27) complained this resident (R22) had inappropriately touched her breast. Resident counseled on behavior. Z4 notified. E1 and E2 (Director of Nurse) aware. 06/25/11 9:35 pm - This resident with a male peer's room (R23) lead a female (R19) into male peer's room. This writer was alerted by the Director of Social Worker, right away went to the rooms of the residents peer and found they did have a female into the room but were unable to take advantage of her, was not enough time.	F9999		

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F9999	Continued From page 55 Female (R19) was led out of the room by this writer both males were counseled as to that kind of behavior and consequences of such. PSRD (Psychosocial Rehab Service Director) was notified. Assistance Director of Nurses was notified. On 7/13/11 at 3:00pm, E6 (PRSD) told the survey team, R22 and R23 were spotted on 6/25/11 by the 4th floor nurse, coming off elevator with R19. The nurse became suspicious when all 3 entered a 4th floor room and closed the door. The nurse decided to see what was going on. She knocked on the door, observed R19 sitting on a bed with one of the male residents. The second resident was standing. The nurse quickly went over to R19 and escorted her out of the room. On 7/14/11, the incident with R19, R22 and R23 was discussed with E8 (R19's PRSC). E8 said she did not observe the incident. "I was walking by another case manager's office, who is inexperienced on what to do. He is no longer here. He told me what happened. I immediately put R19 on 15 minute monitoring. I told R19's CNA on the 2nd floor not to let her go off the floor. R19 is a poor decision maker." E8 was asked how did she know something was wrong? E8 replied, "R19 is generally on the 1st, 2nd and 5th floors only." The incidents on 6/14 and 6/25/2011 were only documented in the social services notes in R22's and R23's record. No other interventions were done beyond the date of the incidents to protect R19 and R27 after the facility was alerted to the sexual predatory behaviors of R22 and R23.	F9999		

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F9999	Continued From page 56 On 7/13 at 4:00 PM E6 (PSRD -Psychosocial Rehabilitation Services Director) was asked for incident reports or any information regarding these incidents. E6 replied, "No formal investigation was done." E6 was also asked if she considered the incident of 6/14/11 (touching of R27's breast) abuse. E6 replied "No." Documentation shows that R22 was not attending any programs for his inappropriate behavior and the care plan approaches/interventions were not revised or updated for the inappropriate behaviors E26 (Certified Nurse Aide) on 07/13/11 at 2:30pm in the nurse station stated," R22 slept a lot. He did not participate in any group program." No documentation was found to show that R23's inappropriate behaviors were being addressed or that a reassessment of his group participation had been done. E26 (Certified Nurse Aide) on 07/13/11 at 2:30pm in the nurse station stated, "R23 did not go to group programs all the time. He refused most of the time. He is very active and moving all the time." R22 and R23 were also noted to be on the facility Identified Offender list. 2. R14's nursing note dated 4/24/11 documents an incident that was entered at 7:50 pm. It states that a peer approached R14 for sexual favors. When R14 was asked about the incident she stated that R31 had approached her and "took his thing out." She pointed to her groin area and	F9999		

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then stated, "You know his man parts." "I went and told security right away." E17's (nurse) report stated that this was reported by E16 (social worker) and she was going to fill out a behavioral observation assessment sheet.

Observation reports for R31 dated 4/26, 4/27,and 4/28 documents sexually inappropriate behaviors.

On initial psychiatric evaluation from hospital admission dated 5/24/11, it is documented that the reason for referral, "I flashed one of the staff and I was sent here."

On the Emergency room report dated 5/25/11, in the major complaint section it is written that R31 "was sexually inappropriate with a peer and non-redirectable."

On 5/23/11 at 9:30 pm, a nursing note states that R31 again has had inappropriate sexual behaviors toward peers. It also says he is not redirectable. He was sent out to the hospital for a psychiatric evaluation.

On 7/13/11 at 2:25 pm, E15 (PRSC) stated that R31 was being counseled and he was following him for those behaviors.

No investigation of R31's alleged sexual behavior toward R14 was done, and nothing was done to protect R14 from further harassment. In addition, there was no review of R31's psychosocial programing to address R31's continued sexual inappropriate behaviors toward females.

3. Social service progress notes on 7/03/2011 at

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F9999	Continued From page 58 8:38am stated, "R20 was found touching himself while watching a female peer who lives across the hall." Care plan dated 7/08/2011 noted R20's behavior of masturbating while looking at a female peer (R10) in a room across from R20. The care plan did not include any changes in R20's psychosocial programs for this behavior. On 7/13/2011 at 4:00pm, an incident report or investigation was requested regarding the incident of 7/03/2011 involving R10 and R20. No nurse's notes or incident reports were produced with any details of this incident nor was any action taken to protect the female residents. No investigations were done. On 7/13/2011 at the daily status meeting E1 (administrator) stated the abuse coordinator is rotated among the administrative staff members. This included E6 (PRSD/ Psychiatric Rehabilitative Service Director). On 7/14/2011 at 10am, E6 (PRSD) discussed the incident with the survey team. E6 reported the incident was not investigated and no incident report was generated. R20 was in the room at the time the nursing staff witnessed the inappropriate behavior. R10 was interviewed and reported she knew nothing about it. R10 was asleep at the time. E6 presented no documentation showing these statements. E6 was asked if she considered this and any other inappropriate sexual behaviors discussed with the facility as abuse. E6 stated "No, it would not be considered abuse."	F9999		

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F9999	Continued From page 59 On 7/14/2011 at 1:10pm, E8 (PRSC/psychosocial rehabilitative service coordinator) stated that R20 was placed in a sexual education program after the incident. However, R20 has not attended the program. E8 reported that a CNA (Certified Nursing Assistant) made E8 aware of the incident. The CNA provided E8 with a behavior occurrence sheet. E8 was asked that if a male resident does public masturbation,visible to female residents, and someone comes and tells them, what would you consider that? E8 replied, "abuse". The facility was aware of the ongoing problems with these residents and addressed these problems as "behaviors" only and not as sexual aggression toward the females in the facility. The facility's policy and procedures for abuse prevention and reporting had the following definition: "Sexual abuse includes but is not limited to, sexual harassment, sexual coercion, sexual assault, resident to resident non-consensual sexual acts, or staff to resident sexual abuse." The facility staff failed to recognize resident behaviors that constituted sexual abuse (as defined by their policy) and did not protect the female residents from further sexual harassment by the above named residents. (A) 300.4010a) 300.4010b)	F9999		

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F9999	Continued From page 60 300.4020a) 300.4030g)1)2) 300.4030h) 300.4030o) 300.4060a) 300.4060b)2) Section 300.4010 Comprehensive Assessments for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S a) The facility shall establish an Interdisciplinary Team (IDT) for each resident. The IDT is a group of persons that represents those professions, disciplines, or service areas that are relevant to identifying an individual's strengths and needs, and that designs a program to meet those needs. The IDT includes, at a minimum, the resident; the resident's guardian; a Psychiatric Rehabilitation Services Coordinator (PRSC); the resident's primary service providers, including an RN or an LPN with responsibility for the medical needs of the individual; a psychiatrist; a social worker; an activity professional; and other appropriate professionals and care givers as determined by the resident's needs. The resident or his or her guardian may also invite other individuals to meet with the IDT and participate in the process of identifying the resident's strengths and needs. b) The IDT must identify the individual's needs by performing a comprehensive assessment as needed to supplement any preliminary evaluation conducted prior to admission to the facility. The assessment shall be coordinated by a PRSC. Section 300.4020 Reassessments for Residents with Serious Mental Illness Residing in Facilities	F9999		

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F9999	Continued From page 61 Subject to Subpart S a) At least every three months, the PRSC shall document review of the resident's progress, assessments and treatment plans. If needed, the PRSC shall inform the appropriate IDT members of the change in resident's condition. The appropriate IDT member will reassess the individual and update the resident's assessment, assuring the continued accuracy of the assessment. Section 300.4030 Individualized Treatment Plan for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S g) ITP Documentation: 1) Significant events that are related to the resident's ITP, and assessments that contribute to an overall understanding of his/her ongoing level and quality of functioning, shall be documented. 2) The resident's response to the ITP and progress toward goals shall be documented in progress notes. h) The ITP shall be reviewed by the IDT quarterly and in response to significant changes in the resident's symptoms, behavior or functioning; sustained lack of progress; the resident's refusal to participate or cooperate with the treatment plan; the resident's potential readiness for discharge and actual planned discharge; or the resident's achievement of the goals in the treatment plan. o) The PRSC shall assess the reason for the failure to attend whenever a resident fails to	F9999		

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F9999	Continued From page 62 attend at least 50 percent of any programs included in his or her ITP over a 30 day period. Within 14 days after noting this failure, the PRSC shall document why the resident's attendance was less than 50 percent and that the resident's attendance is, at the time of the documentation, more than 50 percent, or the PRSC shall conduct an IDT meeting. This IDT meeting shall result in a change in components of the resident's treatment plan or shall indicate why a change is not needed. Section 300.4060 Discharge Plans for Residents with Serious Mental Illness Residing in Facilities Subject to Subpart S a) As part of the ITP, a discharge plan shall be considered by the interdisciplinary team as a component of the individual's comprehensive program plan. This plan shall address the reduction of symptoms and the acquisition of behaviors and prioritized skill deficits that inhibit the individual from moving to a more independent environment. b) Within one year prior to a planned discharge, preparation shall address: 2) Self-directed initiation and compliance with mental health services while in the facility; These Requirements were not met as evidenced by: Based on observation, record review and interview the facility failed to provide ongoing structural programing, individualized needs or goals based on the comprehensive assessments, modification for identified negative behaviors, low	F9999		

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RAINBOW BEACH CARE CENTER	7325 SOUTH EXCHANGE CHICAGO, IL 60649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 63 or absent group attendance, discharge planning and resident's refusal of medical treatment for 9 of 24 sampled residents with serious mental illness (R2, R10, R14, R17, R18, R19, R20, R22 and R23) and 1 resident on the supplemental sample (R31). Findings include: 1. The nurse's notes for R22 are as follows: 07/3/11 4:55pm - Security came up to the floor with resident (R26) when I was passing medication stating that resident (R22) came to her room with (R23) soliciting sex, touching her. Staff called resident (R22) to inquire what happen. Resident (R22) refused. Resident (R22) refused whenever necessary medications. I didn't do anything to receive another medication. Z4 notified of resident behaviors who gave order to transfer resident to hospital. Local police report was made when resident R26 told E8 that R22 penetrated in her. After all investigation by local police resident was arrested by police and escorted out of the facility at 8:36pm. 06/25/11 9:35 pm - This resident with a male peer's room (R23) lead a female (R19) into male peer's room. This writer was alerted by the Director of Social Worker, right away went to the rooms of the residents peer and found they did have a female into the room but were unable to take advantage of her, was not enough time. Female (R19) was led out of the room by this writer both males were counseled as to that kind of behavior and consequences of such. Psycho Rehab Service Coordinator was notified. Assistance Director of Nurse was notified.	F9999		

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F9999	Continued From page 64 06/14/11 7:00pm - Resident was involved in incident another resident (R27) complaint this resident had inappropriately touched her breast. Resident counseled on behavior. Z4 notified. E1 and E2 (Director of Nurse) aware. E26 (Certified Nurse Aide) on 07/13/11 at 2:30pm in the nurse station stated," R22 slept a lot. He did not participate in any group program." R22 was not attending any programs for his inappropriate behavior. The care plan approaches/intervention was not revised or updated for the inappropriate behavior. No reassessment of behaviors were found. The facility did not present any evidence of R22 attending psychosocial groups while in the facility. 2. The nurse's notes state for R23: 07/3/11 4:55pm - Security came up to the floor with resident (R26) when I was passing medication stating that resident (R22) came to her room with (R23) soliciting sex, touching her. Staff called resident (R22) to inquire what happen. Resident (R22) refused. Resident (R23) was given whenever necessary medications. Z4 notified of resident behaviors who gave order to transfer resident to hospital. Local police report was made when resident R26 told E8 that R22 penetrated in her. After all investigation by local police resident was arrested by police and escorted out of the facility at 8:36pm. 06/25/11 9:35 pm - This resident with a male	F9999		

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F9999	Continued From page 65 peer's room (R23) lead a female (R19) into male peer's room. This writer was alerted by the Director of Social Worker, right away went to the rooms of the residents peer and found they did have a female into the room but were unable to take advantage of her, was not enough time. Female (R19) was led out of the room by this writer both males were counseled as to that kind of behavior and consequences of such. Psycho Rehab Service Coordinator was notified. Assistance Director of Nurse was notified. E26 (Certified Nurse Aide) on 07/13/11 at 2:30pm in the nurse station stated," R23 did not go to group programs all the time. He refused most of the time. He is very active and moving all the time." The facility did not present any evidence of R23 attending psychosocial groups while in the facility. No reassessment was found regarding his attendance in programs. 3. R20 is a 44 year old male, who was admitted to the facility on 12/15/2011. R20 has a diagnosis of schizophrenia. On 7/18/2011 the facility presented a list of behaviors recorded by staff for R20. On 4/21/2011 there was physical aggression behavior noted. 7/03/2011 at 8:38am, social service progress stated: " R20 was found touching self while watching a female peer who lives across the hall." 7/04/2011 5:28pm, indicated the resident being sexually inappropriate towards a female peer	F9999		

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F9999	Continued From page 66 again on 7/03/2011. R20's nurse's notes had the following documented: -5/09/2011 6:30pm, Per writer, in verbal altercation with peer, relate to money/food. Haldol 5mg (milligram) given put on fifteen minute monitoring. -4/18/2011 12:15pm, Resident escorted to second floor nursing station by staff. Resident involved in verbal and physical altercation with peer on the first floor. -4/11/2011 2:30pm, Resident on every fifteen minute checks, due to behavior of anxiety towards peer. These checks remain in place until 4/15/2011 10pm, Resident on every fifteen minute checks, related to increase agitation. -4/09/2011 12pm, Resident became extremely agitated when peer asked for some beverage. Resident unable to be redirected by becoming loud and using foul language. Resident then began exhibiting threatening behavior by picking up, opening and throwing ice cooler on floor while yelling loudly. Code yellow called and PRN (as needed medication) given. -1/08/2011 6pm, Resident at nursing station loud irritable slightly verbally agitated. Haldol 5mg received. R20 on 4/18/2011 was hospitalized for uncontrollable aggressive behavior. R20 was re-admitted 4/25/2011 after this hospitalization. R20's care plan dated 4/18/2011 with target dated of 7/07/2011 identified a problem of moderate risk for aggression. The programing was for R20 to attend was anger management. The care plan does not reflect any changes after	F9999		

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R20's behaviors of 7/18/2011. Also, the care plan dated 5/12/2011 did not address R20's verbally aggression with a peer on 5/09/2011. The interventions did not include any changes in R20's planned programing.

The signed attendance's sheets for R20 between 5/07 and 6/18/201 showed, R20 attended once in May and three times in June, with one day 6/18/2011, R20 attended two for anger management group.

Care plan dated 7/08/2011 noted R20 behavior of masturbating while looking at a female peer in a room across from R20. The care plan did not include any changes in R20's psychosocial program.

On 7/14/2011 at 1:10pm, E8 (PRSC) told the surveyor R20 was placed in a sexual education program after the incidence. However, R20 has not attended the program.

4. R2 is a 49 year old resident with a diagnosis of schizophrenia. R2 had a stroke and has right sided weakness.

On 7/11 and 7/12/2011 the surveyor observed R2 during the morning and afternoon hours (10am- 2pm). R2 was found in the room mostly in bed sleeping, the exception of one time. 7/11/2011 at 1:20pm, R2 was engaged in television. R2 was not present in any of the scheduled activity or psychosocial groups.

R2's care plan (treatment plan) dated 6/07/2011, stated R2 was referred to the symptom management sills group, recreation for leisure

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F9999	Continued From page 68 skills group and MISA (mentally ill substance abuse) programing. On 7/14/201 at 1:10pm E8 (PRSC-Psychosocial Rehabilitation Services Coordinator) reported R2 only has a community access pass with family members. E8 confirmed R2 returned from a family visit with evidence of alcohol consumption. E8 stated, R2 was referred to the recreation for leisure skill group, so the resident to could manage his time and not consume alcohol. E8 explained the facility has open psychosocial group in which any resident could attend and all residents are encouraged to go. On 7/18/2011 the surveyor received requested signed attendance sheets for R2's groups attended between 01/2011 and 07/2011. -Symptom management skill training-Monday, Thursday and Saturday at 6:30pm. The sign in sheets reflected regular attendance with the exception of the January, February and July 2011. No evidence of attendance was provided from July 1 and July 16, 2011. In February 2011, R2 attended 5 of 12 days scheduled. In January 2011, R2 attended 2 of 14 days scheduled. -Recreation for leisure skill- Tuesday Friday and Sunday at 6:30pm. -MISA group -twice a week at 10am or 11am . The sign in sheets reflected the following: July 2011 R2 attended 2 of 4 days scheduled. June 2011 R2 attended 5 of 10 days scheduled. May 2011 R2 attended 0 of 10 day scheduled. April 2011 R2 attended 0 of 8 days scheduled. March 2011 R2 attended 3 of 10 days scheduled. February 2011 R2 attended 0 of 8 days scheduled. January 2011 R2 attended 2 of 8 days scheduled.	F9999		

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F9999	Continued From page 69 The majority of R2's planned programing is scheduled at night and R2 is allowed to plan and structure the day. R2 is not structuring the day with any planned groups as shown by attendance sheets. E8 reported R2 being intoxicated post home visit and the facility still maintains home pass privilege for this resident. No evidence was found that family education was done. In addition, there is no evidence of what the facility did when R2 did not attend at least 50% of the scheduled planned programing. 5. R10 is a 55 year old resident with a diagnosis of schizophrenia. On 7/11 and 7/12/2011 between 10am and 2:30pm, R10 was not engaged any type of scheduled activity or psychosocial groups. R10 ambulated (pacing) between the first and five floors hallway. Visiting the first floor activity room at times, but not actively participating. R10's social services notes had the following documented: -5/05/2011 11:14pm, Resident spoke with PRSC (psychiatric rehabilitation service coordinator) regarding employment. Resident raised her voice, used profanity and became verbally aggressive. Resident is not medication compliant and does not appear to have an understanding of her mental illness. R10 was encouraged to comply with treatment program care plan, attend social service groups and become medication compliant. -6/24/2011 8:22am, May monthly note: Resident has not shown significant progress within the last	F9999		

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month. Resident has attended some programming due to her desire to be involved in the work program. Resident is medication and ADL (activity of daily living)compliant. Resident had no behavior.
-7/03/2011 at 5:01pm, June monthly note: Resident has not shown significant progress within the last month. Resident has attended some programming. Resident will be see walking up and down the hallways.
-7/06/2011 The writer met with resident to attempt to contact a community college to set up a tour of the culinary school.

R10's nurse's notes had the following:
-6/29/2011 9pm, resident noted with small boil to left groin area. Resident refused to take PO (by mouth) antibiotics. Also noted from 6/30/2011 10am thru 7/07/2011 9am, R2 refused to be assessed for the boil and topical antibiotic.
-4/10/2011 8am, Resident refused to sign medication consent forms. 3/05/2011 Refused Prolixin decanoate. 1/26/2011 2pm, resident refused 9am medication. 1/08/2011 5pm, Resident refused Prolixin Decanoate.

Lab reports dated 07/23, 06/14 and 11/08/2011 documented R10's refusal for ordered labs for haldol blood levels, HGBA1C(glucose blood measurement), CBC(complete blood count), basic metabolic panel, lipid profile and TSH (thyroid level).

Dental evaluation dated 6/23/2011 documented R10's refusal for examination.

R10's care plan (treatment plan) dated 5/25/2011 stated, R10 to attend a group or activity of R2's

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choice. On 7/14/2011 the surveyor asked E6 (PRSD/ psychiatric rehabilitative service director) for R10's psychosocial assessment. The care plan does not address R10's refusal for medical and nursing intervention, with the exception of medication.

On 4/20/2011 R10 signed a notice of the consequences of a failure to comply with treatment and failure to attend programs at the facility. In this acknowledgement, it states, if R10 continue to refuse to comply with treat, R10 may be issued a thirty-day notice of involuntary discharge. On 7/13/2011 4pm, during the daily status meeting, E1 (administrator) stated, R10 thirty day notice was not done because, R10 agreed to do the work program.

On 7/13/2011 at 11am, E20 (social service clinical director) stated R10 was no longer non compliant with medication in the last two months. R10 has attended some groups and is on the facility's work program. E20 stated the facility is working to get R10 into one of the city's community college. R10 expressed an interest in culinary school. E20 reported that he had helped R10 fill out an application for a government grant.

Record review had no assessment completed to indicate R10 could qualify for college level courses.

On 7/14/2011 R10's requested psychosocial assessment and history was received from E9 (PRSD-Psychiatric Rehabilitation Services Director). The assessment contained a functional assessment but no social history, including educational background. E9 stated it could not

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F9999	Continued From page 72 be complete due to R10's refusal to answer questions. On 7/14/2011 E8 (PRSC) was asked about R10's assessed needs for specialize rehabilitation and/or discharge. E8 reported the goal is for R10 to be medication complaint and attend group on regular basis. E8 was not able to verbalize if R10 had qualification for entering college courses. E8 stated, E20 was working on this information. E8 reported R10 is apart of the facility's work program for mail delivery once a week. The comprehensive care plan does not include the purpose of R10's work program and related goals for the resident. The facility provided R10's sign in attendance sheets from 1/14 thru 7/14/2011. The sign in attendance sheets showed R10 attending groups between 5/15 and 7/12/2011. R10 attended a total of 13 group sessions within a 90 day period. R10 attended one group in July 2011(during the survey), 7/12/2011 at 3pm. The facility's intervention was encouragement from the staff, to comply. There is no evidence for a planned on-going structural psychosocial program for R10. 6. R19 was observed 7/11/11 in the Socialization psychosocial program starting at 10am. There were 18 residents present at the time of the observation. 16 residents were sitting and two were standing. One of the two was R19. E15 (PRSC) was conducting the program. R19 was standing behind E15 with a paperback book and pen in her hand. R19 was writing in the book. Several minutes into the sessions, R19 started	F9999		

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speaking out loud and gesturing toward the wall opposite where she was standing. E15 asked the residents what they had learned since they had been in the group? R1 said, "Nothing. This is boring." R19 continued escalating. E15 turned to look at her, but never ask her to leave or make her join the group in conversation. R1 was interviewed concerning his remarks in the session. "This is an open group, I come for the tokens." R1 further stated that he had been in the facility for two months. "I am only here because, I was put out of where I was living. I went to the hospital and wound up here." E15 was interviewed and asked what was the purpose of the "Socialization psycho-social session". E15 said it was an open group and not a skills group. Anyone can come.

On 7/12/11 at 11am, E6 (PRSD) and E15 were interviewed concerning R19 and the psycho-social programing she was receiving. E6 confirmed that R19 has a short attention span and becomes disruptive during program session. "R19 goes to the open groups and when she becomes disruptive, she is escorted out out of the group." 7/11/11, R19 became disruptive in the Socialization group, but was not escorted out. E6, further added that R19 attends her literary group. The literary group is a writing group. E6 displays some of the poems written by residents on her office door. E6 was asked if R19 writes in sentences. "No, she copies words."

E8 (PRSC) is R19's PRSC. E8 stated on 7/13/11 at 1pm,"R19 has a short comprehension span. She reads words, but does not know what they mean. R19 does not write in sentences, only copies words. She would not benefit from a

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F9999	Continued From page 74 literary group writing poem, one teaching rudimentary writing skills." R19 scored a "6" under Cognitive Patterns in her Minimum Data Set (MDS) dated 5/23/11. A score of 6 means the resident is severely impaired. R19 does not have an individualized psycho-social program to meet her needs and cognitive status. 7. R17 is a 39 year old identified offender. R 17 had a physical altercation on 6/26/11. R17 is scheduled to attend a Socialization Group and Open Groups per his choice. On 7/14/11 at 2:00 p.m., E8 (case manager) reported that R17 does not attend any assigned groups, but E8 encourages him to go to groups. After further review it was noted that R17 returned back to the facility on 7/2/11 after his admission to hospital. There were no new changes to the treatment program or the care plans after he returned to the facility. 8. On 7/13/2011 at 2:00 PM R31 is seen outside in courtyard of facility. There are quite a few residents playing basketball. R31 is a member of the team. During the 20 min observation resident stands off too the side and does not participation the game. After this observation the resident was asked about what groups he attended. He reports "I go to Healthy Choices." He doesn't offer any other information. The social service notes from 7/4, 5/24, and 4/19/2011 all refer to "Issues regarding program attendance have been addressed." R31 has a history during the stay at this facility of inappropriate behaviors including sexual behaviors. No reassessment of	F9999		

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F9999	Continued From page 75 R18's treatment plan or care plan was found to address the inappropriate behaviors. 9. On 7/12/2011 R14 is observed in the dining room eating pizza between the hours of 1:30 pm and 3:00 PM. Her medication class started at 2:30PM. No staff who were present in the area at the time encouraged R14 to go to the planned group session. No follow up was done by the PRSC to find out why R14 did not attend the group, 10. On July 11,2011 at 2:10p.m, R18 came in to attend the creative writing group class that started at 2:00p.m. E6 (PRSD - Psychiatric Rehabilitation Services Director) informed R18 that is now too late to join the class. R18 became agitated and aggressive, slamming on the door and banging on the walls in the hallway and using profanity. R18 was on the facility list of identified offender lists, has multiple episodes of aggressive behavior toward peers (4/21, 4/24, 4/29, 5/1, 6/28/11). On 7/12/11 at 9:50a.m., E7 (PRSC - Psychiatric Rehabilitation Services Coordinator) stated R18 was not care planned for aggression towards others in the current care plan. On 7/14/11 at 8:50a.m E8 (PRSC) stated R18 is not in any aggressive individualized behavior management group but was placed on open groups. E8 (PRSC) also stated R18 was just being "childish." On 7/12/11 and 7/13/11, R18 was not observed attending any group and he stated he cannot find	F9999		